RI Health Reform Commission - Executive Committee Meeting

Meeting Minutes, July 8, 2011
1:30pm

Attendees:
Lt. Governor Elizabeth Roberts – Present
Director of Administration Richard Licht – Present
Secretary of Health and Human Services Steven Costantino – Present
Health Insurance Commissioner Christopher Koller – Present
Governor's Policy Director Brian Daniels - Present

1. Call to Order
    - Lt. Governor Roberts called the Executive Committee session to order at 1:45pm with all members present.
    - An overview of the items to be discussed in the meeting was given. By request, Commissioner Chris Koller presented on where the Rate Review Grant is heading in more detail. The group then discussed how to move forward with the Health Insurance Exchange.
2. Rate Review Grant Discussion
    - Commissioner Koller presented a slide presentation, available on the website of the Rhode Island Healthcare Reform Commission.
    - A question was raised about the fifth slide of the presentation: "Is there any way to tease out the relationship between shifting and directing for the difference in hospital inpatient and hospital outpatient utilization?" There was no data available at the time to answer this question.
    - A point was made that public health is something that improves affordability but it's not something that health plans can control on their own.
    - The eighth slide noted that nationally and internationally you cannot find a high performing health plan without primary care as its base, and yet policy does not focus on it as much as expected.
    - The ninth slide dealt with the idea of having a common contract across all providers so that someone isn't getting a special deal. It was noted that Medicare would be "joining the party" this year. A possible opportunity was considered by aligning with the Beacon Project and American Recovery and Reinvestment Act dollars. A question was asked regarding numbers on the top 50 providers, and how they are defined. It was explained that there are 50 individual doctors, and that 13 sites are groups. It was pointed out that that would imply 1,200 patients per doctor, and it was asked if this was rational. A question was asked regarding what the same service and range of payments were before for standard payments. The answer was that there was a fee for service, an index to a percentage of what Medicare pays, usually around 80%-120% of Medicare, and therefore the change is an improvement. It was explained that the fee for service is not standard. The nature of the enhancement was explained as $5 per member per month, with the aim of making this more of an incentive to be in primary care. It was noted that this is still a pilot project, and that Medicare has a project that goes beyond this and so does BCBS. Further incentives to the provider were described, such as how round 2 of the contract sets forth improvement standards, and how to get more money. Significant Pay for Performance (hereafter PFP) would be available for this, so therefore there would not only be benefits, but a loss of revenue otherwise. It was stated that if

hospital admissions and the ER do not change, they could lose revenue by the second year.

- Slide 11 dealt with increasing transparency and public accountability.
- Slide 13 – Seven contracts were renegotiated. It was explained that there were concerns in the lawsuit about the ways in which the conditions were promulgated. It was noted that Care New England and United are not exempted from other negotiations.
- It was explained that the purpose of this is to show to the federal government that Rate Review is necessary but not enough, and needs to be combined with the interagency delivery system reform efforts.
    i. It was asked if "phase 2" of this grant is a competitive grant, or a natural follow-up to the phase 1 grant. It was explained that while it is competitive, application for phase two is contingent on meeting certain requirements. Under regulation two, a request was made to explain the units of service under standard number 4. The answer given was that the amount of payment was proportional to the amount of work. It was also explained that hopefully with new standardization, particularly with Medicare and Medicaid, this system would end. It was asked how affordability standards affect the rate review process. The response was that there is not a formula; there is an expectation that health plans will set this up, and accountability to the public will hopefully hold them to this.
    ii. It was asked if there was a transcript of a public hearing concerning regulation 2. The answer was that a transcript was not yet available, but the comments ranged from multiple pages to fairly cursory comments on various sides of the issues.
    iii. It was asked if recommendations to the governor on a rate review grant would have any impact on regulation two. The answer was the monies would pay for monitoring the percentage of health insurance spent to pay for staff, and it commits the state to monitoring activities.
    iv. It was commented that some of that money was needed for data development. It was emphasized that if the Governor endorses the grant it doesn't mean he supports regulation two. It was stated that this grant endorsement should not offer full endorsement of regulation 2.
    v. One distinction was raised that the affordability standards in regulation two are being used, but are not locked in, and other options are being explored.
- It was noted that this should not be the last time that this topic is discussed, and that the discussion connects a lot of the work going on in the state.
- There was no objection to recommending the governor write a letter for this cycle 2 grant.
- There was a request for a summary of the legislation that may have passed on this subject.

3. Health Insurance Exchange Discussion
    - Discussion began on additional options on the health insurance exchange since the desired language for the exchange did not pass the assembly before the end of session.
    - It was stated that the efforts that the LG and the office of the LG made to try to get the bill passed were extraordinary, and that she should be applauded for going as far as possible to make sure it was compatible.
    - A presentation was given on a possible new avenue of creating the exchange, but there was no deliberation in this meeting on it.

- Jennifer Wood, Chief of Staff to the Lieutenant Governor, began the presentation.
    i. It was stated that exchange legislation was unsuccessful, but in the absence of authorizing legislation, there are other means for establishing an exchange. It was stated that if the issue that intervened in passage of the legislation had been probitions on public funding for abortion coverage, that would have been relatively straightforward to address, but because the issue that ultimately held up the legislation dealt with restrictions on the private purchase of coverage, that was more difficult to address, and thus forced the group to consider path B in the absence of successful legislation.
    ii. Options for establishing the exchange without legislation were presented. It was explained that Federal funders will accept a properly constructed Executive Order with appropriate authorities as an alternative to legislation, but that this would need to be in place and designated prior to September to meet the next available application timeline for federal funds.
- Topher Spiro from the Lieutenant Governor's office continued the presentation on statutory authority for the Exchange.
    i. The fifth slide dealt with the Health Resources development fund, the broadest, most comprehensive and most flexible statute that provides a mechanism for establishing an exchange.
    ii. The sixth slide dealt with how this would align with the purposes of a health benefits exchange.
    iii. While discussing the seventh slide it was pointed out that point one is not unique. It was clarified that this is correct but in this statute there is reinforcing language for that point.
- Ms. Wood presented on what the Executive order would do and what it would need to include.
    i. The tenth slide dealt with different options and structures within government for the exchange. It was explained that the governor is the appointing authority of the board in this model, as he would have been in the legislation.
    ii. The eleventh slide identified at least three options for how the governor could frame the executive order. Details of each option were presented. The most simple and direct option is Option 1 – retaining the project at the Department of Health. Option 2 would involve creating an independent division within an existing state department other than health. Option 3 would involve the creation of a governmentally chartered not for profit. While this is being done elsewhere in the country further research would be required as to viability of this option in the RI context.
    iii. The thirteenth slide stated that if a new division is delegated this authority which cannot promulgate regulations, then it would be regulated by Health.
    iv. Slide 15 was a reminder that the purpose of the presentation was not to evaluate the options, but to put them on the table.
- Dan Meuse from the Lieutenant Governor's office presented on why in March the Executive Committee had decided to recommend a quasi-public model.
    i. The sixteenth slide asked for an evaluation of which of the options would work best in a bureaucracy.

ii. The seventeenth slide dealt with the necessity of being able to talk to insurers and work with them, and the fact that some options may function better when they are self-sustaining and politically neutral.
iii. Slide 19 dealt with the pros and cons of each location for the exchange.
iv. Slide 20 laid out the pros and cons generated by the Lt. Governor's office, and stated that other opinions would be added in the next meeting. Rhode Island Quality Institute or BCBS were given as possible analogies to option 3. Benefits and drawbacks from the committee were asked to be brought forward.
    1. It was explained that the exchange would operate on federal funds through 2015, and that after that time it would need to be a self-sustaining institution.
    2. It was explained that the funds are naturally segregated, but that the federal requirements should be investigated as well.
    3. It was asked if there is any non-diversion language in the ACA, and no response was readily available. Risks were raised in creating funds for the exchange that could become "scoop money" if there was a surplus. Ideas for funding were raised, such as charging fees for each transaction. It was clarified that exchange operational costs would need to be covered by the funding for the exchange.
    4. It was clarified that the committee needs to decide if the exchange will be a clearinghouse for premium payments or not.
    5. The importance of this issue was noted to indicate why the exchange needs to be a flexible institution. It was emphasized that on a theoretical basis, any one of these options can function with either a fully functional exchange or a minimal exchange, but that over the next 10 days the committee would figure out the most likely choices of each and what can accommodate those or facilitate those choices.
    6. It was explained that the first two options would make it easier to transition later if the General Assembly passes legislation creating a quasi-public entity subsequently. It was clarified that option two would have mechanisms to delegate rule-making authority.
    7. It was noted that the population served by the exchange would be less than those served by Medicaid.
- It was noted that there will be a discussion on Monday by the stakeholder group on this same topic, and that there is a special meeting scheduled on July 18 to develop a proposal with options to take to the governor.

4. New Business/Public Comment
5. Adjourn – Meeting adjourned at 3:31pm.